## STATE OF MONTANA DEPARTMENT OF PUBLIC HEALTH AND HUMAN SERVICES

## APPLICATION FOR FULL CERTIFICATION AS A MENTAL HEALTH PROFESSIONAL PERSON

## PART II - EMPLOYMENT INFORMATION

**TO THE APPLICANT:** Provide the information requested below to claim credit for work experience required for certification. If you have had more than one work experience which you want to claim, make additional copies of this form so that each job is documented. After completing A through E below, send the form to the person who supervised your work (or another authorized representative of the employer) for verification. The supervisor should forward the form directly to the Certification Committee.

olio	cant:		
	Employer:	Phone: ()	
	Address:	<del></del>	
	Name of Supervisor:	<del></del>	
	Dates of Employment: From through		
	Job Title:	_	
	(If part-time, hours per week:)		
	Is this employer an agency, organization, or unit within an organizatreatment of mental disorders?  Yes No Not Sure	tion in which the primary purp	ose is the
	What percentage of your time in this job was spent:		
	providing direct mental health services to seriously mentally ill personal	ons?	%
	evaluating persons for possible serious mental illness?		%
	doing long term treatment planning for seriously mentally ill persons	3?	%
	Other major duties:		
			%
			%
			%
			%
			%
			%
		TOTAL	% 100 %

E	Describe briefly,	in narrative form, the nature of the work you performed for this employer.
as a respo	mental health profe onsibilities, including mitment hearings at ties. Your signatu	The person named above is an applicant for certification by the State of Montana essional person. Montana law gives to mental health professional persons a number of ag the authority to provide expert testimony regarding need for institutionalization at and to develop and supervise treatment plans for individuals in mental health inpatient are below indicates that you have read the information provided by the applicant in this form and that <i>you certify that the information is true to the best of your</i>
Signa	ature of Employer:	
Printe	ed Name and Title:	
	Date:	
Retui	rn this form to:	Professional Person Certification Committee Addictive & Mental Disorders Division P.O. Box 202905

Helena, MT 59620-2905